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	17E531	A. BUILDING _____ B. WING _____	02/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This Requirement is not met as evidenced by: The facility reported a census of 40 residents. The sample included 18 residents, with 3 reviewed for dignity. Based on observation, interview, and record review, the facility failed to promote care in a manner and an environment that enhanced the dignity and respect, for 1 (#4) of the 3 residents, with coverage of the urinary catheter drainage bag. Findings included: - A review of resident #4's computerized medical record face sheet, revealed an admission date of 5/5/08. A quarterly MDS (Minimum Data Set) assessment, dated 1/31/13, revealed the resident as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15. The resident required total dependence of 2 or more staff for toilet use. The resident used an external catheter and frequently incontinent. The care plan, reviewed on 1/29/13, directed staff, "... I need [external] catheter care each shift and PRN [as needed]. I wear a [external] catheter. ...I would like to wear briefs/ pull-ups for	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 241	Continued From page 1 dignity purposes." On 2/12/2013 at 7:30 AM, the resident rested in bed, with the urinary catheter drainage bag lacking a cover and left the resident's urine exposed in the drainage bag. A cloth dignity coverage bag hung from the resident's wheelchair, across the room. At 3:00 PM, direct care staff M and X repositioned the resident and checked the external catheter placement. Staff M positioned the catheter tubing to drain the urine into the dependent drainage bag, then removed the cloth dignity bag and hung the drainage bag, with exposed urine, onto the bed frame. The cloth dignity bag fell from the bed onto the floor. Staff X picked up the dignity bag from the floor. Staff X stated, "Just put it over there," and pointed to a chair. The staff failed to cover the resident's urine collection bag to promote dignity for the resident. On 2/13/13 at 7:30 AM and at 9:18 AM, the resident rested in bed, with the dependent catheter drainage bag hung, uncovered, from the bed frame on the room door side, and in full view of anyone walking past the resident's room. At 12:06 PM, the resident rested in bed, with the dependent catheter drainage bag hung from the bed, on the room door side. Direct care staff R and V repositioned the resident up in bed, and staff V took the dependent drainage bag from the bed frame and the hung it back onto the bed frame, lacking a dignity covering. When questioned about the dignity bag, staff V replied, "Not usually [used] when [the resident] is in bed... [The dignity bag] is used when the resident is up in the chair around people... Is it suppose to be?" Staff R added, "Night shift takes it [the cloth	F 241		

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F 241	Continued From page 2	F 241		

dignity bag] off when they take off [the resident's] pants and stuff." Staff R and V confirmed the dignity bag used for, "Privacy." Staff R and V placed the dignity bag over the dependent catheter drainage bag following the conversation.

On 2/13/13 at 4:50 PM, the resident rested in bed, with the dependent catheter drainage bag in a cloth dignity bag, hanging on from the bed frame, on the wall side of the bed. Direct care staff M removed the dependent drainage bag from the dignity bag and emptied the urine from it. Staff M removed the cloth dignity bag from the bed frame and hung the dependent drainage catheter bag on the bed frame without coverage. Staff M reported the cloth dignity bag, "To cover, for privacy... We leave it on sometimes, but we usually take it off when we lay [the resident] down at night. ...It just depends. We don't have to have it on. It just depends on the CNA [certified nurses aide]."

On 2/14/13 at 9:05 AM, administrative nursing staff A reported, "We don't normally cover them [the dependent catheter drainage bag] in their private room. ...It would probably be a good idea to hang it on the side away from the door. ...In [the resident's] private room I believe it does not need to be in a dignity bag,...it needs to be in one when [the resident] comes out. When questioned if family/ visitors could see the dependent catheter drainage bag from the hall, staff A reported, "If the door is open they could."

On 2/14/13 at 2:50 PM, licensed nursing staff C, reported the dependent catheter drainage bag should remain, "In one of those privacy cloth bags, and affixed to the chair so it won't drag...In bed, it hangs below, on the bed frame..." Staff C confirmed the dignity bag should be used, "I

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F 241	Continued From page 3 usually see that it's covered with the [cloth dignity bag], or the blankets... There was one [dignity bag] on the dependent catheter drainage bag, on the bed, when [the resident] went to the hospital." The facility failed to provide a policy related to maintaining the residents' dignity related to coverage of the residents' urinary catheter bag. The facility failed to ensure this resident's dignity enhanced, with coverage of the urinary dependent catheter drainage bag, to ensure the resident's urine remained out of full view to visitors and/or other residents.	F 241		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit;	F 272		

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F 272	Continued From page 4 Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This Requirement is not met as evidenced by: The facility reported a census of 40 residents with 18 selected for sample review. Based on interview and record review, the facility failed to comprehensively and thoroughly assess 9 of the selected residents, including; #35 for Falls; #33 and #6 for ADL (activities of daily living) Functioning/Rehabilitation Potential; and #35, 31, 29, 33, 9, 20, 39, and 4 for psychotropic drug use, to assist in the development of any individualized, comprehensive plan of care, for instruction to staff to consistently meet the resident's needs. Findings included: - The facility admitted resident # 35 on 1/31/13, per the computer clinical record. The resident's 3/1/12 admission MDS (minimum data set) assessment, identified a BIMS (brief interview of mental status) score of 0, indicating severely impaired cognitive status, without any mood or behavior concerns, needed extensive assistance of 1 staff for ADL's (activities of daily living), including transfers and mobility, identified	F 272		

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falls prior to admission, and received antipsychotics, antianxiety, and antidepressants (psychotropic medications).

The resident's 3/2/12 CAA (care area assessment), lacked identification of causal factors and analysis findings for falls or psychotropic medication usage.

On 2/13/13 at 10:45 AM, administrative nursing staff A, reported, "This is not a complete CAA...That is not how they are now...since October [2012]."

The facility failed to thoroughly assess the resident for psychotropic medication use and fall risk, to assist in the development of any individualized, comprehensive plan of care, for instruction to staff to consistently meet the resident's needs.

- The facility admitted resident # 31 on 2/2/11, per the computer clinical record.

The 2/14/12 annual MDS (minimum data set), identified the resident with a BIMS (brief interview of mental status) score of 3, indicating severely impaired cognitive skills, exhibited disorganized thinking, without moods or behaviors, needed supervised assistance of 1 staff for ambulation, and extensive assistance of 1 staff for transfers, and received anti-depressants (psychotropic medications).

The 2/15/12 CAA (care area assessment), lacked identification of any causal factors and analysis of the resident's psychotropic medication use.

On 2/13/13 at 10:45 AM, administrative nursing

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staff A, reported, "This is not a complete CAA...That is not how they are now...since October [2012]."

The facility failed to thoroughly assess the resident for the use of psychotropic medication use, to assist in the development of any individualized, comprehensive plan of care, for instruction to staff to consistently meet the resident's needs.

- The facility admitted resident # 29 on 4/8/11, per the electronic record.

The resident ' s 8/7/12 annual MDS (minimum data set) assessment, identified the resident scored 2 on the BIMS (brief interview of mental status), indicating severely impaired cognitive skills, exhibited delusions, and received anti-depressant and diuretic therapy medications.

The CAA (care area assessment) dated 8/8/12, for psychotropic medication use lacked completion, and failed to identify causal factors or analysis of the findings related to psychotropic drug use.

On 2/13/13 at 10:45 AM, administrative nursing staff A, reported, "This is not a complete CAA...That is not how they are now...since October [2012]."

The facility failed to thoroughly assess the resident for psychotropic medication use, to assist in the development of any individualized, comprehensive plan of care, for instruction to staff to consistently meet the resident's needs.

- The medical record's undated face sheet

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documented resident # 33 admitted to the facility on 11/28/11.

The 7/10/12, significant change MDS (minimum data set), identified the resident with a BIMS (brief interview for mental status) score of 15 (13-15 indicates intact cognition). The assessment further documented the resident required total assistance with most ADLs (activities of daily living), with impairment on both right and left sides, and both upper and lower extremities with functional limitation in range of motion. The assessment also documented the resident received antipsychotic medication including, antidepressants, and an antibiotic, in the last 7 days, during the look back period.

The CAA (Care Area Assessment) dated 7/11/12, lacked documentation of the casual factors and lacked analysis for the resident's psychotropic drug use.

On 2/13/13 at 10:35 AM, , administrative nursing staff A, confirmed,"This is not a complete CAA...That's not how they are now. ...since October."

On 2/14/13 at 11:45, administrative nursing staff A reported, "We don't have a CAA policy."

The facility failed to thoroughly assess the resident for use of psychotropic medication use, to assist in the development of an individualized, comprehensive plan of care, for instruction to staff to consistently meet the resident's needs.

- The medical record's undated facesheet documented, resident # 20 admitted to the facility on 6/8/10.

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F 272	Continued From page 8 The 12/11/12, significant MDS (minimum data set), identified the resident with a BIMS (brief interview for mental status) score of 3 (0-7 indicates cognition severely impaired). ADL (activities of daily living) identified the resident required supervision with eating and extensive assist with remaining ADLs. Furthermore, the resident received psychotropic medications including antidepressants, antianxiety, antipsychotic medications. The CAA (Care Area Assessment), dated 12/12/12, lacked documentation of casual factors and lacked analysis for the resident's psychotropic drug use. On 2/13/13 at 10:35 AM, , administrative nursing staff A, confirmed,"This is not a complete CAA...That's not how they are now. ...since October." On 2/14/13 at 11:45, administrative nursing staff A reported, "We don't have a CAA policy." The facility failed to thoroughly assess the resident for use of psychotropic medications to assist in the development of an individualized, comprehensive plan of care, for instruction to staff to consistently meet the resident's needs. - The medical record's undated facesheet documented, resident # 9 admitted the the facility on 4/24/12. The 5/2/12 annual MDS (minimum data set) documented a BIMS (brief interview for mental status) score of 6 (0-7 indicates cognition severely impaired). Furthermore, the resident received psychotropic medications including	F 272		

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antidepressants.

The CAA (Care Area Assessment), dated 12/12/12, lacked documentation of casual factors and lacked analysis for the resident's psychotropic drug use.

On 2/13/13 at 10:35 AM, , administrative nursing staff A, confirmed,"This is not a complete CAA...That's not how they are now. ...since October."

On 2/14/13 at 11:45, administrative nursing staff A reported, "We don't have a CAA policy."

The facility failed to thoroughly assess the resident for use of psychotropic medication use to assist in the development of an individualized, comprehensive plan of care, for instruction to staff to consistently meet the resident's needs.

- A review of resident #4's computerized medical record face sheet, revealed an admission date of 5/5/08, with diagnoses including long term use of medication.

An annual MDS (Minimum Data Set), dated 4/30/12, revealed staff assessed the resident as moderately impaired cognitively with a BIMS (Brief Interview for Mental Status) score of 11. Staff assessed the resident with, "No behaviors documented." The resident required 6 days of antipsychotic and 7 days of antidepressants (psychotropic medications).

The CAAs (Care Area Assessments), dated 5/1/12, failed to thoroughly assess any contributing and/or causal factors related to the resident's "Psychotropic Drug Use."

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On 2/13/13 at 10:35 AM, administrative nursing staff A confirmed, "This not a complete CAA... That is not how they are now... since Oct [2012].

On 2/14/13 at 11:45 AM, administrative nursing staff A reported, "We don't have a CAA policy."

The facility failed to thoroughly assess for any contributing and/or causal factors related to the resident's "Psychotropic Drug Use," to assist in the development of an individualized, comprehensive care plan to instruct staff to meet this resident's needs.

- A review of resident #39's medical record, electronic face sheet, revealed an admission date of 6/8/12.

An admission MDS (Minimum Data Set), dated 6/15/12, revealed staff assessed the resident as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 14. Staff assessed the resident with, "No behaviors exhibited," and 7 days of antipsychotic and antianxiety medications and 4 days of antidepressants medication use (psychotropic medications).

The CAAs (Care Area Assessments), dated 6/18/12, failed to thoroughly assess any contributing and/or causal factors related to the resident's "Psychotropic Drug Use."

On 2/13/13 at 10:35 AM, administrative nursing staff A confirmed, "This not a complete CAA... That is not how they are now... since Oct [2012].

On 2/14/13 at 11:45 AM, administrative nursing staff A reported, "We don't have a CAA policy."

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F 272	Continued From page 11 The facility failed to thoroughly assess for any contributing and/or causal factors related to the resident's "Psychotropic Drug Use," to assist in the development of an individualized, comprehensive care plan to instruct staff to meet this resident's needs. - The facility admitted resident #6 on 10/07/2003, per the clinical face sheet, dated 5/13/2011. The POS (Physician's Order Sheet), dated, 1/21/13, documented included diagnosis of, multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord) and polyneuropathy (any disorder or affliction of peripheral nerves). The annual MDS (minimum data set) dated 5/07/2012, identified the resident with moderate cognitive impairment, and without mood or behavior indicators. The resident required extensive assistance of one staff assisting with eating, total dependence with one staff assisting with bathing, total dependence with two or more staff assist with bed mobility, transfer, dressing, toilet use and personal hygiene. Furthermore, the resident experienced limits in range of motion ability in both upper and lower and both right and left sides of the body. The CAA (care area assessment), dated 5/8/13, failed to assess any contributing factor and/or causal factors related to ADL Functional/Rehabilitation Potential. On 2/13/13 at 10:35 AM, administrative staff A, confirmed, " This is not a complete CAA (care area assessment) ...That is not how they are done ...since October [2012]. "	F 272		

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F 272	Continued From page 12 The facility failed to thoroughly assess for any contributing and/or causal factors related to the resident's "ADL [activities of daily living] Functional/Rehabilitation Potential," to assist in the development of any individualized, comprehensive plan of care, for instruction to staff to consistently meet the resident's needs.	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by: The facility reported a census of 40 residents with 18 selected for sample review. Based on interview and record review, the facility failed to review and revise 3 of the 18 residents' care plans, including; # 11 for psychotropic medication use, #41 for fall interventions, and # 39 for sleep hygiene interventions.	F 280		

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Findings included:

- The facility admitted resident # 11 on 1/26/12, per the computer clinical record.

The resident's 2/1/13 annual MDS (minimum data set) identified the resident with a BIMS (brief interview of mental status) score of 3, indicating severe cognitive impairment, inattention and disorganized thinking, occasional rejection of cares, needed limited to extensive assistance of ADL's (activities of daily living) including mobility and hygiene, and received antipsychotic and antidepressant medications. However, the assessment failed to identify the use of an anti-anxiety medication.

The 2/5/13 CAA (care area assessment) for psychotropic's identified the resident required monitoring for side effects, adverse reactions, drug to drug interactions, and black box warnings for all their medications and further noted to review progress notes from the resident's geri-psychiatric hospitalizations. The summary additionally, included diagnoses of dementia and depression, a history of alcohol abuse, not reversible, with ongoing treatments, and continued with psychotropic medication usage to treat dementia and depression. The CAA also failed to identify the resident's use of an antianxiety medication.

The resident's 2/2/12 care plan instructed staff in the resident's care needs, related to short and long term memory loss... The care plan further instructed staff to monitor for side effects, adverse drug reactions, and drug interactions...administer...lorazepam 0.5 mg bid, ... The facility failed to accurately review and

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revise the resident's care plan in relation to this medication dose reduction, dated 11/1/12.

A physician order, dated 11/1/12, instructed the staff to administer Lorazepam (an antianxiety medication), 0.25 mg (milligrams), twice daily, and decreased from 0.5 mg, twice daily.

Direct care staff D reported on 2/13/13 at 10:30 AM, the resident adjusted well to life in the unit, attended the activities of their choice, attended most meals, and generally seemed content. Staff D added, the resident rarely exhibited behaviors, any longer.

Administrative nursing staff A, reported on 2/14/13 at 4:30 PM the resident admitted to the unit from another unlocked long term care facility. The staff added the resident adapted well to the unit, and actually seemed much more relaxed and at ease.

The facility failed to review and revise the resident's plan of care to include the physician ordered dose reduction of the resident's antianxiety medication.

- A review of resident #39's medical record, electronic face sheet, revealed an admission date of 6/8/12, with diagnoses including: insomnia (inability to sleep).

A quarterly MDS (Minimum Data Set), dated 12/15/12, revealed staff assessed the resident as moderately impaired cognitively with a BIMS (Brief Interview for Mental Status) score of 9. The resident identified as independent with no set-up or physical help from staff for bed mobility, transfer, walk in room or corridor, and locomotion

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F 280	Continued From page 15 on the unit; and limited assistance of 1 person for dressing, toilet use, and personal hygiene. The care plan, dated 12/11/12, directed staff, "Please administer my medications as prescribed. Please have my physician review my medications and dosage. ...Watch me for possible changes in my behavior: withdrawal, increased anxiety, etc [etcetera]. ...Watch me for possible mental changes- decline in memory, attention span, etc. I take trazodone PRN [as needed] for insomnia." An additional "Medication Care Plan," dated 1/22/13, listed the side effects and common administration instructions for the resident's medications. However, the facility staff failed to revise this resident's care plan to include any non-pharmacological interventions to provide prior to administration of the resident's trazodone medication used for sleep. . A review of the eMAR (electronic medication administration record), on 2/13/13 at 3:16 PM, revealed the resident received the trazodone nightly for the past 6 of 6 nights, and documented, "Per resident's request." On 2/13/13 at 3:25 PM, The resident confirmed frequently taking the sleeping pill, and reported "I have trouble getting to sleep... We tried everything, they sang to me... I've read until I'm sleepy, but as soon as I quit reading I'm awake." On 2/13/13 at 3:40 PM, direct care staff W confirmed the resident does take a sleeping pill, and stated, "Yes, and [the resident] will ask for it every night... and [the resident] will call for it." When asked if the facility attempted other alternatives to the sleeping medication, staff W replied, "Sometimes, but [the resident] is very persistent [about getting the sleeping	F 280		

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medication]."

On 2/13/13 at 3:50 PM, direct care staff M confirmed the resident receives a sleeping pill, and "[The resident] sleeps pretty good... [He/She] asks for it [the sleeping medication], sometimes." Staff M reported being unaware of any non-pharmacological interventions attempted prior to administration of the medication for sleep, "That would be the med aide [the certified medication aide] or the nurse."

On 2/13/13 at 4:00 PM, licensed nursing staff Z reported the resident received Trazodone, "For insomnia." Staff Z reported non-pharmacological interventions attempted included, "[The resident] takes [his/her] showers before bed. Some times [he/she] sits and listens to some program on the TV [television], ...says it's relaxing. ...[The resident] does this things on [his/her] own." Staff Z added, "[The resident] requests [the sleeping medication] every night. If [he/she] forgets, once [the resident] remembers [he/she] asks for it... [He/She] wakes up at 2:00 in the morning and asks for it. ...[The resident] is used to taking it and [he/she] feels like [he/she] needs it." Staff Z confirmed the care plan lacked any non-pharmacological interventions for the sleep medication, and stated, "I don't think it's in the care plan."

At 4:07 PM, administrative nursing staff A confirmed the care plan lacked sleep hygiene interventions, and that non-pharmacological interventions should be included.

The facility provided a, "Sleep Hygiene" policy, dated "February 2013," which revealed, "... Shall attempt individualized non-pharmacological approaches (including direct care and activities)

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that are provided as part of a supportive physical and psychosocial environment, and are directed toward accommodating a resident's sleep. Non-pharmacological interventions shall be attempted prior to using pharmacological interventions..."

The facility failed to review and revise the care plan to include any non-pharmacological interventions for this resident to accommodate sleep prior to the administration of the sleep aide medication.

- The facility admitted resident #41 on 10/5/12 , per the clinical face sheet, dated 12/12/12.

The admission MDS (minimum data set), dated 10/12/12, identified the resident with severe cognitive impairment. The resident required, extensive assistance with 2 or more staff for bed mobility, transfers, walk in room, walk in corridor, locomotion on unit, dressing, toilet use and personal hygiene. The resident had reported falls in the 1-6 months prior to admission.

The CAAs (care area assessment), for falls dated 10/23/2012, revealed, "Resident has a history of falls at home prior to admission. He/she has not fallen in the hospital or since admission to [the facility]."

The resident's care plan, dated 1/22/13, directed staff, "I need staff assistance for all my personal hygiene as I am not safe doing these things on my own. I require assistance of 1 staff member for bed mobility. I require standby assistance for all transfers and ambulation so I am safe from falling. I use special equipment to help with ADL's [activities of daily living]...equipment includes walker. Please do not tell me that I just

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used the bathroom when I ring for assistance to void." The plan of care lacked revision to include interventions to prevent repeated falls, after the resident with a fall history, fell on 1/19/13. Furthermore, the care plan lacked the resident's current use of a alarm while in the bed to prevent falls from the bed.

An untimed, nurses progress note, dated 1/19/13, documented, "During ambulation in bedroom, knees buckled, staff was able to lower resident to floor before a fall occurred."

The following nurses progress note, dated 1/21/13 untimed, documented, "Fax sent to physician to request X-ray of left thigh/knee due to c/o [complaints of] pain after resident's knee buckled this weekend and is not wanting to stand well. If no injury noted, also asked for order for PT [physical therapy] to evaluate and treat."

A fax, dated 1/21/13 at 1400, documented, "Over the weekend while ambulating [the resident's] left knee buckled and [the resident] was lowered to the floor. He/she is now complaining of pain to the left thigh, to just below the left knee. He/she is refusing to stand. 1.) Can we have order for x-ray to left thigh/knee? 2.) If no injury, can we have order for PT (physical therapy) to eval (evaluate) and treat?"

An x-ray report, dated 1/22/13 at 1:02 PM, of the resident's knee, documented, "Knee joint effusion without evidence of acute fracture or subluxation."

An untimed, nurses progress note, dated 2/9/13, documented, "Resident is becoming more dependent on staff. At times, refuses to participate in his/her care..."

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On 2/13/13 at 4:40 PM, direct care staff V and M, used a sit to stand mechanical lift to transfer the resident from the recliner to the wheelchair. The resident required cueing to hold onto the lift during the transfer.

On 2/13/13 at 7:40 AM, direct care staff V stated, "The resident doesn't try to get up out of bed, and has an alarm just in case."

On 2/13/13 at 4:40 PM, direct care staff Y, stated, "He/she has bad knees and they started giving out."

On 2/13/13 at 7:45 AM, licensed staff C, stated "The resident has a bed alarm just in case he/she should try to get up. He/She gets impatient."

The facility, "Fall Prevention" policy, updated August 2011, revealed, "...If the resident should fall: a.) Assess the resident for injury, including vital signs...b.) place the resident on the hot rack file for 24 hours with a witnessed non-injury fall and 48 hours with an injury fall or witnessed fall. Document the resident's condition each shift for 48 hours...Notify the resident's primary care physician of the fall...If there is no injury, the physician may be notified during regular business hours...Complete a fall assessment and investigation report. Document the fall and interventions in the Accident/Injury section of Optimus [computer system]."

The facility failed to review and revise the resident's care plan to include interventions implemented after the resident's fall on 1/19/13, to prevent repeated falls during transfers/ambulation, and failed to revise the care plan to include the bed alarm currently used by the resident to prevent repeated falls from the

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F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility reported a census of 40 residents. The 18 residents selected for review, included 3 reviewed for accidents. Based on observation, interview and record review, the facility failed to provide adequate supervision and/or assistive devices to prevent repeated accidents for 1 (#41) of the 3 selected residents. Findings included: - The facility admitted resident #41 on 10/5/12 , per the clinical face sheet, dated 12/12/12. The POS (Physician's Order Sheet), dated 12/1/12, documented a diagnosis of Senile Dementia (A progressive mental disorder characterized by failing memory, confusion). The admission MDS (minimum data set), dated 10/12/12, identified the resident with severe cognitive impairment. The resident required, extensive assistance with 2 or more staff for bed mobility, transfers, walk in room, walk in corridor, locomotion on unit, dressing, toilet use and personal hygiene. The assessment also documented repeated falls in the 1-6 months	F 323		

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prior to admission.

The CAAs (care area assessment), for falls dated 10/23/2012, revealed, "Resident has a history of falls at home prior to admission. He/she has not fallen in the hospital or since admission to [the facility]."

The resident's care plan, dated 1/22/13, directed staff, "I need staff assistance for all my personal hygiene as I am not safe doing these things on my own. I require assistance of 1 staff member for bed mobility. I require standby assistance for all transfers and ambulation so I am safe from falling. I use special equipment to help with ADL's [activities of daily living]...equipment includes walker. Please do not tell me that I just used the bathroom when I ring for assistance to void."

A fall risk assessment, completed 10/5/12, revealed the resident at risk for falls with a score of 21, and a score greater than 10 being at risk for falls.

A fax to the physician, dated 1/21/13 at 1400, documented, "Over the weekend while ambulating [the resident's] left knee buckled and [the resident] was lowered to the floor, he/she is now complaining of pain to left thigh to just below left knee. He/she is refusing to stand. 1.) Can we have order for x-ray to left thigh/knee? 2.) If no injury, can we have order for PT (physical therapy) to eval (evaluate) and treat?

An x-ray report, dated 1/22/13 at 1:02 PM, documented, "Knee joint effusion without evidence of acute fracture or subluxation."

An untimed, nurses progress note, dated 1/19/13,

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documented, "During ambulation in bedroom, knees buckled, staff was able to lower resident to floor before a fall occurred."

The following nurses progress note, dated 1/21/13 and without a time, documented, "Fax sent to physician to request X-ray of left thigh/knee due to c/o [complaints of] pain after resident's knee buckled this weekend and is not wanting to stand well. If no injury noted also asked for order for PT [physical therapy] to eval and treat."

An untimed, nurses progress note, dated 2/9/13, documented "Resident is becoming more dependent on staff. At times, refuses to participate in his/her care..."

On 2/13/13 at 4:40 PM, direct care staff V and M, used a sit to stand mechanical lift to transfer the resident from the recliner to the wheelchair. The resident required cueing to hold onto the lift during the transfer.

On 2/13/13 at 7:40 AM, direct care staff R, stated "[The resident] fell, it scared him/her and then he/she just gave up, doesn't try to get up alone."

On 2/13/13 at 7:40 AM, direct care staff V stated, "The resident doesn't try to get up out of bed, and has an alarm just in case."

On 2/13/13 at 4:40 PM, direct care staff Y, stated, "He/she has bad knees and they started giving out."

On 2/13/13 at 7:45 AM, licensed staff C, stated "The resident has a bed alarm just in case he/she should try to get up. He/She gets impatient."

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F 323	Continued From page 23 On 2/14/13 at 1:20 PM, administrative staff A, stated "There is no incident report...They[staff] were with him/her the whole time...lowered him/her to the floor so the resident didn't fall." The facility Fall Prevention policy, updated August 2011, revealed, "...If the resident should fall: a.) Assess the resident for injury, including vital signs...b.) place the resident on the hot rack file for 24 hours with a witnessed non-injury fall and 48 hours with an injury fall or witnessed fall. Document the resident's condition each shift for 48 hours...Notify the resident's primary care physician of the fall...If there is no injury, the physician may be notified during regular business hours...Complete a fall assessment and investigation report. Document the fall and interventions in the Accident/Injury section of Optimus [computer system]." The facility failed to provide adequate supervision and/or assistive devices to prevent repeated falls, for this resident with a history of falls.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug	F 329		

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therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This Requirement is not met as evidenced by:
The facility reported a census of 40 residents with 18 selected for sample review. Based on interview, and record review, the facility failed to ensure 6 of the 10 residents reviewed for unnecessary medications, remained free of unnecessary medications, including; #, 31, and 33 for lack of follow-up for prn (as needed)medications; #35 and 20 for lack of laboratory testing to monitor medications; and #35, 29 and 43 for lack of adequate diagnosis for medications to ensure medication necessity for the residents.

Findings included:

- The facility admitted resident # 29 on 4/8/11, per the electronic clinical record.

Diagnosis from POS (Physician's Order Sheet), dated 1/4/13 included: "...Other persistent mental disorders and 'see chart for more conditions'." Additionally, the POS included the following orders:

1. Acetaminophen Suppository, 650 mg (milligrams), administer rectally as needed, every 4 hours for Dementia (Dementia- progressive

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mental disorder characterized by failing memory, confusion) CCE (cranial compliance elasticity) with behavioral disturbances, ordered 2/23/12. (An analgesic/pain medication.)
2. Acetaminophen tablets, 325 mg, administer 2 tablets, by mouth, as needed, every 4 hours for Dementia CCE with behavioral disturbances, ordered 10/29/11. (An analgesic/pain medication.)

3. Sinemet, 25/250 mg, by mouth 3 times per day, for other persistent mental disorder, ordered 11/1/11. (An anti-parkinsonism medication.)

4. Mirapex, 0.75 mg, 1 tablet, by mouth, 3 times per day, for Dementia CCE with behavioral disturbances, ordered 6/26/12. (An anti-parkinsonian medication.)

The resident's 8/7/12 annual MDS (minimum data set) assessment, identified the resident scored 2 on the BIMS (brief interview of mental status), indicating severely impaired cognitive skills, exhibited delusions, and received anti-depressant and diuretic therapy medications.

The CAA (care area assessment) for cognition and psychotropic medication use, lacked completion, and failed to identify causal factors or analysis of the findings related to psychotropic drug use.

The Geriatric Dosage Handbook, 16th Edition, page 254, identified the medications included; Sinemet classified as an anti-parkinsonian agent; Mirapex, page 1444, as an anti-parkinsonian agent; and Acetaminophen, page 30, as an analgesic.

On 2/14/13 at 4:40 PM administrative nursing

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F 329	Continued From page 26 staff A reported the resident had a diagnosis of Parkinson's (Parkinson's disease- a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, mask-like faces, shuffling gait, forward flexion of the trunk, loss of postural reflexes and muscle rigidity and weakness) and it should have been clarified for the use of Mirapex and Sinemet. Consultant staff N, reported on 2/18/13 at 4:40 PM, the resident's medications, as noted above, exhibited inappropriate diagnosis, and required clarification. The facility failed to ensure the resident remained free of unnecessary medications, with the failure to ensure the proper diagnosis attached to the medications ordered/prescribed, to ensure the resident received adequate and appropriate monitoring for these medications. - The facility admitted resident # 35 on 2/23/12, then re-admitted the resident on 1/31/13, per the resident's clinical electronic record. Diagnosis from the resident's clinical record, POS (Physician's Order Sheet), dated, 1/31/13, included left femoral neck fracture, and left distal radius comminuted intra-articular fracture with left hip endoprosthesis and left wrist closed reduction percutaneous pinning with ex-fix placement (fracture of the left hip and of the left wrist with surgical repair). Additionally, the POS included the following medications: 1. Tylenol Extra Strength (Acetaminophen) 500 mg (milligrams), by mouth, every four hours, as needed, for pain/increased temperature, ordered 1/31/13. (An analgesic/pain medication.)	F 329		

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2. Lortab (hydrocodone/acetaminophen) tablet, 7.5/500 mg, every 4 hours as needed for pain, ordered 1/31/13. (A narcotic analgesic/pain medication.)

3. Clonazepam (an anti-anxiety medication), 0.25 mg disintegrating tablet, by mouth 2 times per day, for Dementia (Dementia- progressive mental disorder characterized by failing memory, confusion), CCE (cranial compliance elasticity) with behavioral disturbances. (An anti-convulsant/anti-anxiety medication.)

The resident's 3/1/12 admission MDS (minimum data set) assessment, identified the resident with severe impairment of cognition, needed extensive assistance of 1 staff for ADL's (activities of daily living), without any mood or behaviors, experienced falls, and received anti-psychotic, anti-anxiety and anti-depressant medications.

Review of the 3/2/12 CAA (care area assessment), lacked identification of causal factors and analysis of findings for the resident's psychotropic medications.

A 12/1/12 quarterly MDS, identified the staff assessed the resident with short and long term memory impairment, indicating severe impairment of decision making skills, without mood or behavior concerns, needed extensive assistance of 1 staff for ADL's, including walking in room and unit, and received anti-psychotic and anti-depressant medications.

The resident's 3/5/12 care plan, instructed staff, "The resident received anti-psychotic medications..., to administer ...Clonazepam, 0.5 mg, by mouth, twice daily for anxiety..."

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F 329	Continued From page 28 A 2/23/12 physician signed standing order included: 1.) Lipids every year. 2.) Microalbumin every year. 3.) SGPT (serum glutamic oxaloacetic transaminase) and SGOT (serum glutamic pyruvic transaminase) every 90 days. Review of the resident's clinical record included the following laboratory results: 1.) SGOT and SGPT drawn on 2/28/12. However, the resident's medical record lacked any lab results for 5/12, 8/12, and 11/12, as ordered by the physician. 2.) A lipids level drawn on 8/10/11. However, lacked results for 8/12, as ordered. 3.) The resident's clinical record lacked results of any Microalbumin, as ordered. Review of the resident's PRN (as needed), e-MAR (electronic medication administration record) medications, identified the resident received pain medication (Lortab and Tylenol) on 20 occasions from 1/25/13 to 2/13/13. However, on 9 of those 20 occasions, the staff administered the medications and then staff failed to follow-up on the results of the, as needed,pain medications, effectiveness. On 2/12/13 at 12:47 PM, the resident returned from an appointment with the resident's family. A family member propelled, the resident's wheel chair, into the living area. At that time, observation identified the resident with pins and a fixed rod protruding from the resident's left arm. Staff then propelled the resident to the dining	F 329		

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table for lunch, with the resident holding onto the rod with their right hand. Briefly, the resident stood independently, while seated at the table, then returned to a seated position, in the wheel chair.

Interview with licensed nursing staff E, on 2/13/13 at 4:04 PM, reported a lack of laboratory tests completed, as ordered. Staff E reported being unaware of why the facility staff failed to complete the laboratory tests, as ordered.

On 2/14/13 at 2:56 PM, licensed nursing staff C, reported, "When I give a PRN med [medication] I check the MAR [medication administration record] for the order, assess the resident to determine the problem, then if appropriate I give the med and do the follow-up later. If it is Tylenol, I check to see if they had any med with Tylenol that day. They should not have over 2000 mg [milligrams] a day."

On 2/14/13 at 4:45 PM administrative nursing staff A, reported the staff, had begun looking at lab orders and results for all the residents, "After being made aware yesterday of the [resident's] lack of..." Staff A further reported, "I believe when we went to the computer change over, they somehow got overlooked. I'm getting that corrected right away." Additionally, at that time, staff A reported the pharmacy would be expected to note and recommend changing/clarifying inappropriate medication diagnosis. Staff A further indicated, "They [the nurses and CMA's -certified medication aides] are instructed to do a follow-up with all prn medications."

On 2/18/13 at 4:40 PM, consultant staff N reported the residents needed monitoring for the effectiveness of prn medications, as well as

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ensuring the residents' diagnosis are appropriate and laboratory testing is conducted and monitored, for effective monitoring of the medications.

The facility failed to ensure this resident remained free of unnecessary medications, when the facility failed to monitor the resident for effectiveness of the medications administered, with improper diagnosis of medications, failure to obtain laboratory testing as ordered and failure to complete follow-up monitoring of the medications effectiveness, for this resident.

- The facility admitted resident # 43 on 1/17/13, per the resident's computerized clinical record.

Diagnosis from a 1/17/13 Physician Order Sheet (POS), included: Dementia (A progressive mental disorder characterized by failing memory, confusion.), vascular type, moderate to end stage with hallucinations (Sensing things while awake that appear to be real, but instead have been created by the mind.) Furthermore, the POS identified the following orders:
1.) Acetaminophen, 325 mg (milligrams), 2 tablets, prn (as needed) every 4 hours, for Dementia CCE (cranial compliance elasticity) with behavioral disturbances, ordered 1/17/13. (An analgesic/pain medication.)

2.) Antacid, 225 mg/5 ml (milliliters), 200 mg/5 ml, prn, Dementia CCE with behavioral disturbances, ordered 1/17/13.

3.) Eye Drops, 0.05% solution eyes, both, as needed, for Dementia CCE with behavioral disturbances, ordered 1/17/13.

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F 329	Continued From page 31 The resident's 1/24/13 admission MDS (minimum data set) assessment, identified the resident scored 3 on the BIMS (brief interview of mental status), indicating severely impaired cognitive status) exhibited disorganized thinking, and received anti-psychotic and anti-depressant medications. Review of the Geriatric Dosage Handbook, 16th Edition, identified the following: 1.) Acetaminophen, page 30, an analgesic, and lacked indicators used for Dementia. 2.) Antacid, page 72, identified the medication used as a antacid, and lacked indicators of use for Dementia, as ordered. 3.) Eye Drops, Artificial Tears, page 137, indicated use for relief of dry eyes, and lacked indication for use related to Dementia. Interview on 2/14/13 at 4:35 PM with administrative nursing staff A, reported the facility failed to clarify the physician orders/medications/diagnosis related to the resident's recent admission. On 2/18/13 at 4:40 PM, interview with consultant staff N, reported the resident's diagnosis inappropriate for the medications, as listed above. The facility failed to ensure the resident remained free of unnecessary medications when the facility failed to review and clarify the resident's medication diagnoses for appropriateness to ensure adequate monitoring and effectiveness of the medications.	F 329		

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F 329	Continued From page 32 - The facility admitted resident # 31 on 2/2/11, per the resident's computerized clinical record. The POS (Physician's Order Sheet)/discharge summary, dated 1/25/13, included the following physician orders: 1. Acetaminophen Suppository, 650 mg (milligrams), rectally every 4 hours, as needed, for pain or increased temperature, ordered 1/25/13. (An analgesic/pain medication.) 2. Lorazepam Plogel, 1 mg, topically, as needed, every 4 hours for anxiety, ordered 1/25/13. (An anti-anxiety medication.) Review of the resident's e-MAR (electronic medication administration record), dated 12/16/12 to 2/14/13, identified the resident received the following medications without prn (as needed) follow-up for effectiveness: 1. Acetaminophen/Tylenol, 325 mg, documented as administered on 7 occasions and the staff failed to complete a follow-up assessment on 6 of those occasions related to the effectiveness of the medication. 2. Lorazepam Plogel, 1 mg, administered on 17 occasions and staff failed to complete follow-up on 4 of those occasions, related to the effectiveness of the medications. On 2/14/13 at 2:56 PM, licensed nursing staff C, reported, "When I give a PRN med [medication] I check the MAR for the order, assess the resident to determine the problem, then, if appropriate, I give the med and do the follow-up later. If it is Tylenol, I check to see if they had any med with Tylenol that day. They should not have over 2000	F 329		

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mg a day."

On 2/14/13 at 4:45 PM administrative nursing staff A, indicated, "They [the nurses and CMA's-certified medication aides] are instructed to do a follow-up with all prn medications."

On 2/18/13 at 4:40 PM, consultant staff N reported the resident's needed monitoring for the effectiveness of prn medications.

The facility failed to ensure this resident remained free of unnecessary medications, when the facility staff failed to complete monitoring with follow-up of the effectiveness of the medications when administered.

- Resident # 33 admitted to the facility on 11/28/11.

The 7/10/12, significant change MDS (minimum data set) identified the resident with a BIMS (brief interview for mental status) score of 15 (13-15 indicates intact cognition). The assessment also documented the resident received antipsychotic medications, antidepressants, and an antibiotics.

The resident's medical record revealed a 9/28/12, physician order, for Percocet, (pain medication) 7.5/325 milligrams, by mouth, PRN (as needed) for pain, and on 6/28/12, a physician order for Biscolax suppository (for constipation) 10 milligrams, PRN, every 3rd day if no bowel movement.

The resident's MAR (medication administration record), from 12/15/12 through 1/31/13, documented the staff administered the Percocet medication to the resident on 16 occasions,

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without completion of follow-up monitoring for the medication's effectiveness to the resident.

Further review of the MAR from 12/15/12 through 1/23/13, revealed the staff administered the Biscolax on 4 occasions without completion of follow-up monitoring for the medication's effectiveness to the resident.

On 2/14/13 at 2:56 PM, licensed nursing staff said," When I give a PRN medication, I check the MAR, for the order, assess the resident to determine the problem, if appropriate I give the medication and then do the follow-up."

On 2/14/13 at 5:00 PM, administrative nursing staff A stated, "... The nurse or the CMA (certified medication aide) does the follow-up on the effectiveness of the medication."

The facility failed to complete follow-up monitoring for the effectiveness of the medications provided to the resident as needed.

- The computerized clinical record of resident #20 documented admission to the facility on 6/8/10, with diagnoses including diabetes mellitus (a complex disorder that is primarily a result of a relative or complete lack of insulin secretion by the body) and hypertension (high blood pressure).
The 9/13/12 care plan, documented, "I prefer to sleep in my recliner, instead of bed. Please speak calmly and gently to me especially when I am agitated. I cannot help my mental distress and need people around me that will help to calm my nerves. Please review my medication care plan for side effects, adverse reactions, drug interactions, and black box warnings for my

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F 329	Continued From page 35 anticoagulant therapy and my other medications. The resident's medical record documented a physician order on 2/4/13, included laboratory tests: BUN (Blood,urea,nitrogen), Creatine (a compound produced by the body), CBC (complete blood count), irontibc (total iron binding capacity), Folate,glycosylated HE, Mirco-albumin (random), PT/INR (prothrombin/Internalized Normalized Ratio), SGPT (serum glutamic oxaloacetic transaminase),SGOT(serum glutamic pyruvic transaminase). However, the resident's medical record lacked documentation of the laboratory tests completed as ordered. On 2/14/13 at 5:13 PM, administrative staff A stated, "I see there was an order on 2/4/13 for lab. There are no lab results. I'm not sure why the labs were not done, I will get [the resident] over to have the lab done tomorrow." The facility failed to obtain laboratory tests as ordered by the physician to monitor the effectiveness of the resident's medications.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been	F 334		

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immunized during this time period;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that --
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical

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contraindication or refusal.
(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.

This Requirement is not met as evidenced by:
The facility reported a census of 40 residents with 18 resident's selected for sample review. Based on record review and interview, the facility failed to ensure a signed consent and provision of the risk verses benefit information given to the residents and/or their responsible parties for the current years influenza and pneumococcal vaccines. Additionally, staff failed to offer/provide the influenza and pneumococcal vaccinations to 1 resident (# 35).

Findings included:

- Upon review of 5 residents' medical records, 3 out of 5 residents (# 41, 35 and 11) records lacked documentation of information pertaining to risk verses benefits for the current year's influenza vaccine and the pneumococcal vaccine, had been provided to them or their responsible party.

Review of these residents' medical records included:

1.) Review of resident # 41's clinical record, identified the resident admitted on 10/5/12. Further review of the immunization section of the

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clinical record lacked identification that the facility provided the resident with information related to the vaccines.

2.) Review of the resident #11's clinical record, labeled "Immunization Notes," identified the resident received an influenza and pneumococcal vaccination on 10/1/12 and 11/28/12. However, the record lacked indicators the resident received information for the current risk versus benefits, for the vaccinations prior to the injections.

3.) Review of the resident #35's clinical record, labeled, "Immunization Record," lacked documentation of any type for influenza and pneumococcal vaccination provided in the immunization section. Furthermore, the record failed to identify resident and/or their responsible party received a current risk versus benefit statement related to the vaccinations.

On 2/14/13 at 6:00 PM, administrative nursing staff A reported, the facility as current on vaccinations for the residents, and stated, "I will check on that."

The facility Vaccine Documentation/Consent Form, dated 7/06 included:
"I have been offered a copy of the Vaccine Information Statement(s) (VIS) checked below. I have read, had explained to me, and understand the information in the VIS(s)..."

The facility policy, dated 10/08, for Influenza and Pneumococcal Vaccines, included:
"Beginning each September and going through March, any resident living in our facility or admitted to our facility will be offered the influenza vaccine unless there is documentation of previous immunization for that year or the

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F 334	Continued From page 39 resident has a documented contraindication....Pneumococcal vaccination status will be completed on admission regardless of date. Vaccination will be offered to all patients who cannot provide documentation of previous vaccination. Those who are unsure or do not know of their vaccination status will be immunized." The facility failed to ensure that before offering the influenza immunization, each resident, or the resident's legal representative received education regarding the benefits and potential side effects of the immunizations, and further failed to ensure all resident's received vaccinations, upon admission.	F 334		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: The facility reported a census of 40 residents. Based on observation, interview, and record review, the facility failed to store, prepare and serve foods under sanitary conditions for the residents for the facility. Findings included: - On 2/11/13 at 7:30 AM, the initial kitchen tour,	F 371		

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F 371	Continued From page 40 with dietary staff U, revealed: 1) A bowl of undressed lettuce salad, which lacked a preparation date or any identifying label. Staff U confirmed this salad needed a date and an identifying label. 2) A container of sliced cheese, and luncheon meats (turkey, ham, and other assorted meats), which lacked an opened date or any identifying label. Within the bottom of the container, an accumulation of a liquid pooled, approximately 1/8 inch deep. On 2/13/13 at 10:20 AM, the sanitation kitchen tour, with dietary staff T, revealed: 1) The can opener contained visible food particles and debris at the blade and across the base areas, not easily wiped away. Staff T reported, "The can opener goes in the dishwasher daily, but it and the table needs cleaned." 2) One oven contained a baked-on brown substance around the front edges and in the center of the bottom/floor. 3) Fourteen large loaf pans contained a baked-on, brownish black substance along the insides of the pans. 4) Six bundt pans contained a baked-on, brownish black substance along the insides of the pans. 5) Fourteen full sheet pans, stored together wet, and held a baked-on, brownish black substance along all 4 inside corners of the pans. 6) Four small cookie sheets contained a	F 371		

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baked-on, brownish black substance along the insides of the pans.

7) Seven muffin tins/ pans contained a baked-on, brownish black substance along the insides of the muffin cups.

8) Three large baking pans contained a baked-on, brownish black substance along the insides of the pans.

On 2/13/13 at 1:59 PM, dietary staff S reported, "I do not have cleaning schedules, I just make them keep their [dietary staff] area clean. If on a schedule, it just doesn't work, ...[The dietary staff cleaning their work area] it works fine..."

The facility's undated, policy and procedure for, "Cleaning Instructions: Cleaning Can Opener," revealed, "...Guidelines for cleaning hand held can openers: Remove the can opener shaft from the base... Pay special attention to the blade and moving parts... Wash the base thoroughly with hot detergent water. Be sure to remove all food particles from the blade and base... Repeat guidelines after each use..."

The facility's undated, policy and procedure for, "Cleaning Dishes/ Dish Machine," revealed, "Dishes and cookware will be washed and sanitized after each meal. ...Scrub pots and pans with a non-metallic scouring pad when necessary... Remove the dishes, inspect for cleanliness and dryness, and put them away if clean... If the dishes are not clean, repeat steps 2-8..."

The facility failed to store, prepare and serve foods under sanitary conditions for the residents of the facility.

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F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This Requirement is not met as evidenced by: The facility reported a census of 40 residents with 18 selected for sample review. Based on interview, and record review, the facility pharmacist failed to identify and report irregularities related to medications, to the facility, for 6 of the 10 residents reviewed for unnecessary medications, including; #, 31 and 33, for lack of follow-up for prn (as needed) medications; #35 and 20, for lack of laboratory testing to monitor medications; and #35, 29 and 43 for lack of adequate diagnosis for medications. Findings included: - The facility admitted resident # 29 on 4/8/11, per the electronic clinical record. Diagnosis from POS (Physician's Order Sheet), dated 1/4/13 included: "...Other persistent mental disorders and 'see chart for more conditions'." Additionally, the POS included the following orders: 1. Acetaminophen Suppository, 650 mg	F 428		

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(milligrams), administer rectally as needed, every 4 hours for Dementia (Dementia- progressive mental disorder characterized by failing memory, confusion) CCE (cranial compliance elasticity) with behavioral disturbances, ordered 2/23/12. (An analgesic/pain medication.)
2. Acetaminophen tablets, 325 mg, administer 2 tablets, by mouth, as needed, every 4 hours for Dementia CCE with behavioral disturbances, ordered 10/29/11. (An analgesic/pain medication.)

3. Sinemet, 25/250 mg, by mouth 3 times per day, for other persistent mental disorder, ordered 11/1/11. (An anti-parkinsonism medication.)

4. Mirapex, 0.75 mg, 1 tablet, by mouth, 3 times per day, for Dementia CCE with behavioral disturbances, ordered 6/26/12. (An anti-parkinsonian medication.)

The resident's 8/7/12 annual MDS (minimum data set) assessment, identified the resident scored 2 on the BIMS (brief interview of mental status), indicating severely impaired cognitive skills, exhibited delusions, and received anti-depressant and diuretic therapy medications.

The Geriatric Dosage Handbook, 16th Edition, page 254, identified the medications included; Sinemet classified as an anti-parkinsonian agent; Mirapex, page 1444, as an anti-parkinsonian agent; and Acetaminophen, page 30, as an analgesic.

On 2/14/13 at 4:40 PM administrative nursing staff A reported the resident had a diagnosis of Parkinson's (Parkinson's disease- a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, mask-like

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faces, shuffling gait, forward flexion of the trunk, loss of postural reflexes and muscle rigidity and weakness) and it should have been clarified for the use of Mirapex and Sinemet.
Consultant staff N, reported on 2/18/13 at 4:40 PM, the resident's medications, as noted above, exhibited inappropriate diagnosis, and required clarification.

The facility pharmacist failed to identify and report the irregularity to the facility, with the facility failure to ensure the proper diagnosis attached to the medications ordered/prescribed, to ensure the resident received adequate and appropriate monitoring for these medications.

- The facility admitted resident # 35 on 2/23/12, then re-admitted the resident on 1/31/13, per the resident's clinical electronic record.

Diagnosis from the resident's clinical record, POS (Physician's Order Sheet), dated, 1/31/13, included left femoral neck fracture, and left distal radius comminuted intra-articular fracture with left hip endoprosthesis and left wrist closed reduction percutaneous pinning with ex-fix placement (fracture of the left hip and of the left wrist with surgical repair). Additionally, the POS included the following medications:

1. Tylenol Extra Strength (Acetaminophen) 500 mg (milligrams), by mouth, every four hours, as needed, for pain/increased temperature, ordered 1/31/13. (An analgesic/pain medication.)

2. Lortab (hydrocodone/acetaminophen) tablet, 7.5/500 mg, every 4 hours as needed for pain, ordered 1/31/13. (A narcotic analgesic/pain medication.)

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F 428	Continued From page 45 3. Clonazepam (an anti-anxiety medication), 0.25 mg disintegrating tablet, by mouth 2 times per day, for Dementia (Dementia- progressive mental disorder characterized by failing memory, confusion), CCE (cranial compliance elasticity) with behavioral disturbances. (An anti-convulsant/anti-anxiety medication.) The resident's 3/1/12 admission MDS (minimum data set) assessment, identified the resident with severe impairment of cognition, needed extensive assistance of 1 staff for ADL's (activities of daily living), without any mood or behaviors, experienced falls, and received anti-psychotic, anti-anxiety and anti-depressant medications. Review of the 3/2/12 CAA (care area assessment), lacked identification of causal factors and analysis of findings for the resident's psychotropic medications. A 12/1/12 quarterly MDS, identified the staff assessed the resident with short and long term memory impairment, indicating severe impairment of decision making skills, without mood or behavior concerns, needed extensive assistance of 1 staff for ADL's, including walking in room and unit, and received anti-psychotic and anti-depressant medications. The resident's 3/5/12 care plan, instructed staff, "The resident received anti-psychotic medications..., to administer ...Clonazepam, 0.5 mg, by mouth, twice daily for anxiety..." A 2/23/12 physician signed standing order included: 1.) Lipids every year.	F 428		

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F 428	Continued From page 46 2.) Microalbumin every year. 3.) SGPT (serum glutamic oxaloacetic transaminase) and SGOT (serum glutamic pyruvic transaminase) every 90 days. Review of the resident's clinical record included the following laboratory results: 1.) SGOT and SGPT drawn on 2/28/12. However, the resident's medical record lacked any lab results for 5/12, 8/12, and 11/12, as ordered by the physician. 2.) A lipids level drawn on 8/10/11. However, lacked results for 8/12, as ordered. 3.) The resident's clinical record lacked results of any Microalbumin, as ordered. Review of the resident's PRN (as needed), e-MAR (electronic medication administration record) medications, identified the resident received pain medication (Lortab and Tylenol) on 20 occasions from 1/25/13 to 2/13/13. However, on 9 of those 20 occasions, the staff administered the medications and then staff failed to follow-up on the results of the, as needed,pain medications, effectiveness. On 2/12/13 at 12:47 PM, the resident returned from an appointment with the resident's family. A family member propelled, the resident's wheel chair, into the living area. At that time, observation identified the resident with pins and a fixed rod protruding from the resident's left arm. Staff then propelled the resident to the dining table for lunch, with the resident holding onto the rod with their right hand. Briefly, the resident stood independently, while seated at the table, then returned to a seated position, in the wheel	F 428		

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F 428	Continued From page 47 chair. Interview with licensed nursing staff E, on 2/13/13 at 4:04 PM, reported a lack of laboratory tests completed, as ordered. Staff E reported being unaware of why the facility staff failed to complete the laboratory tests, as ordered. On 2/14/13 at 2:56 PM, licensed nursing staff C, reported, "When I give a PRN med [medication] I check the MAR [medication administration record] for the order, assess the resident to determine the problem, then if appropriate I give the med and do the follow-up later. If it is Tylenol, I check to see if they had any med with Tylenol that day. They should not have over 2000 mg [milligrams] a day." On 2/14/13 at 4:45 PM administrative nursing staff A, reported the staff, had begun looking at lab orders and results for all the residents, "After being made aware yesterday of the [resident's] lack of..." Staff A further reported, "I believe when we went to the computer change over, they somehow got overlooked. I'm getting that corrected right away." Additionally, at that time, staff A reported the pharmacy would be expected to note and recommend changing/clarifying inappropriate medication diagnosis. Staff A further indicated, "They [the nurses and CMA's -certified medication aides] are instructed to do a follow-up with all prn medications." On 2/18/13 at 4:40 PM, consultant staff N reported the residents needed monitoring for the effectiveness of prn medications, as well as ensuring the residents' diagnosis are appropriate and laboratory testing is conducted and monitored, for effective monitoring of the medications.	F 428		

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The facility pharmacist failed to identify and report the irregularity to the facility when the facility failed to monitor the resident for effectiveness of the medications administered, failure to ensure adequate diagnosis of medications, failure to obtain laboratory testing as ordered and failure to complete follow-up monitoring of the medications effectiveness, for this resident.

- The facility admitted resident # 43 on 1/17/13, per the resident's computerized clinical record.

Diagnosis from a 1/17/13 Physician Order Sheet (POS), included: Dementia (A progressive mental disorder characterized by failing memory, confusion.), vascular type, moderate to end stage with hallucinations (Sensing things while awake that appear to be real, but instead have been created by the mind.) Furthermore, the POS identified the following orders:
1.) Acetaminophen, 325 mg (milligrams), 2 tablets, prn (as needed) every 4 hours, for Dementia CCE (cranial compliance elasticity) with behavioral disturbances, ordered 1/17/13. (An analgesic/pain medication.)

2.) Antacid, 225 mg/5 ml (milliliters), 200 mg/5 ml, prn, Dementia CCE with behavioral disturbances, ordered 1/17/13.

3.) Eye Drops, 0.05% solution eyes, both, as needed, for Dementia CCE with behavioral disturbances, ordered 1/17/13.

The resident's 1/24/13 admission MDS (minimum data set) assessment, identified the resident scored 3 on the BIMS (brief interview of mental status), indicating severely impaired cognitive

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status) exhibited disorganized thinking, and received anti-psychotic and anti-depressant medications.

Review of the Geriatric Dosage Handbook, 16th Edition, identified the following:

1.) Acetaminophen, page 30, an analgesic, and lacked indicators used for Dementia.

2.) Antacid, page 72, identified the medication used as a antacid, and lacked indicators of use for Dementia, as ordered.

3.) Eye Drops, Artificial Tears, page 137, indicated use for relief of dry eyes, and lacked indication for use related to Dementia.

Interview on 2/14/13 at 4:35 PM with administrative nursing staff A, reported the facility failed to clarify the physician orders/medications/diagnosis related to the resident's recent admission.

On 2/18/13 at 4:40 PM, interview with consultant staff N, reported the resident's diagnosis inappropriate for the medications, as listed above.

The facility pharmacist failed to identify and report the irregularity to the facility, when the facility failed to review and clarify the resident's medication diagnoses for appropriateness.

- The facility admitted resident # 31 on 2/2/11, per the resident's computerized clinical record.

The POS (Physician's Order Sheet)/discharge summary, dated 1/25/13, included the following physician orders:

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1. Acetaminophen Suppository, 650 mg (milligrams), rectally every 4 hours, as needed, for pain or increased temperature, ordered 1/25/13. (An analgesic/pain medication.)

2. Lorazepam Plogel, 1 mg, topically, as needed, every 4 hours for anxiety, ordered 1/25/13. (An anti-anxiety medication.)

Review of the resident's e-MAR (electronic medication administration record), dated 12/16/12 to 2/14/13, identified the resident received the following medications without prn (as needed) follow-up for effectiveness:

1. Acetaminophen/Tylenol, 325 mg, documented as administered on 7 occasions and the staff failed to complete a follow-up assessment on 6 of those occasions related to the effectiveness of the medication.

2. Lorazepam Plogel, 1 mg, administered on 17 occasions and staff failed to complete follow-up on 4 of those occasions, related to the effectiveness of the medications.

On 2/14/13 at 2:56 PM, licensed nursing staff C, reported, "When I give a PRN med [medication] I check the MAR for the order, assess the resident to determine the problem, then, if appropriate, I give the med and do the follow-up later. If it is Tylenol, I check to see if they had any med with Tylenol that day. They should not have over 2000 mg a day."

On 2/14/13 at 4:45 PM administrative nursing staff A, indicated, "They [the nurses and CMA's-certified medication aides] are instructed to do a follow-up with all prn medications."

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On 2/18/13 at 4:40 PM, consultant staff N reported the resident's needed monitoring for the effectiveness of prn medications.

The facility pharmacist failed to identify and report the irregularity to the facility, when the facility staff failed to complete monitoring with follow-up of the effectiveness of the medications when administered as needed.

- Resident # 33 admitted to the facility on 11/28/11.

The 7/10/12, significant change MDS (minimum data set) identified the resident with a BIMS (brief interview for mental status) score of 15 (13-15 indicates intact cognition). The assessment also documented the resident received antipsychotic medications, antidepressants, and an antibiotics.

The resident's medical record revealed a 9/28/12, physician order, for Percocet, (pain medication) 7.5/325 milligrams, by mouth, PRN (as needed) for pain, and on 6/28/12, a physician order for Biscolax suppository (for constipation) 10 milligrams, PRN, every 3rd day if no bowel movement.

The resident's MAR (medication administration record), from 12/15/12 through 1/31/13, documented the staff administered the Percocet medication to the resident on 16 occasions, without completion of follow-up monitoring for the medication's effectiveness to the resident.

Further review of the MAR from 12/15/12 through 1/23/13, revealed the staff administered the

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F 428	Continued From page 52 Biscolax on 4 occasions without completion of follow-up monitoring for the medication's effectiveness to the resident. On 2/14/13 at 2:56 PM, licensed nursing staff said," When I give a PRN medication, I check the MAR, for the order, assess the resident to determine the problem, if appropriate I give the medication and then do the follow-up." On 2/14/13 at 5:00 PM, administrative nursing staff A stated, "... The nurse or the CMA (certified medication aide) does the follow-up on the effectiveness of the medication." The facility pharmacist failed to identify and report the irregularity of the facility failure to complete follow-up monitoring for the effectiveness of the medications provided to the resident as needed. - The computerized clinical record of resident #20 documented admission to the facility on 6/8/10, with diagnoses including diabetes mellitus (a complex disorder that is primarily a result of a relative or complete lack of insulin secretion by the body) and hypertension (high blood pressure). The 9/13/12 care plan, documented, "I prefer to sleep in my recliner, instead of bed. Please speak calmly and gently to me especially when I am agitated. I cannot help my mental distress and need people around me that will help to calm my nerves. Please review my medication care plan for side effects, adverse reactions, drug interactions, and black box warnings for my anticoagulant therapy and my other medications. The resident's medical record documented a physician order on 2/4/13, included laboratory	F 428		

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F 428	Continued From page 53 tests: BUN (Blood,urea,nitrogen), Creatine (a compound produced by the body), CBC (complete blood count), irontibc (total iron binding capacity), Folate,glycosylated HE, Mirco-albumin (random), PT/INR (prothrombin/Internalized Normalized Ratio), SGPT (serum glutamic oxaloacetic transaminase),SGOT(serum glutamic pyruvic transaminase). However, the resident's medical record lacked documentation of the laboratory tests completed as ordered. On 2/14/13 at 5:13 PM, administrative staff A stated, "I see there was an order on 2/4/13 for lab. There are no lab results. I'm not sure why the labs were not done, I will get [the resident] over to have the lab done tomorrow." The facility pharmacist failed to identify the facility failure to obtain laboratory tests as ordered by the physician, and report this irregularity to the facility.	F 428		